

citizens, both public and private healthcare consumers, unless Evans wishes to claim otherwise, but specifically for research participation itself. This points to an alternative to Evans's obligatory participation—namely, payment offered for participation in research.

In my view, the alternatives to either buying our way out of participation or renouncing the power to veto our participation in research (at least if we wish to be treated) would be: abolition of the extra fee within a well-functioning public health service supported by the community as a whole, both financially and in terms of democratic decision-making processes. The democratic decision-making processes would aim at reaching consensus regarding, among other things, the risks that the members of the entire community would be prepared to take for health-related benefits. This would preserve voluntary participation.

Or, alternatively, preserve the extra fee whereby we understand the payment is offered for research participation itself rather than for medical treatment. This would counteract Evans's alleged justification for abolishing veto to research participation: if it is established that something is owed to the research participants beyond what every citizen contributes to a publicly funded healthcare system through taxation, and Evans seems to think that it does, the obligation could equally, or even more appropriately, be fulfilled by offering them payment. Consequently, their participation in clinical research would be neither obligatory

nor enforceable. Even if, for the sake of argument, this should prove to be a less efficient system than enforcing research participation, efficiency as such is not an ethically sufficient ground for enforcement of a social mechanism or practice. If "fair's fair", this much at least seems to be fair.

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